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ABSTRACT

This paper addresses health and social issues as well as other socioeconomic problems which affect the black family, and the development of appropriate policy and programs to deal with those problems. Data on infant mortality, life expectancy, maternal mortality, physician and dental visits, and some selected death rates from specific causes are provided to illustrate the state of health among blacks in America. Additional data are provided to show the consistency of unemployment, overrepresentation in low-paying jobs, and the continuous decrease in absolute income experienced by black families. It is argued that the problems faced by black families in these areas are the result of discrimination, racism, and selective employment practices. Suggestions are made for developing a community-based health care system that takes into account the socioeconomic problems of blacks and other minorities. (EB)

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ON RELATING HEALTH CARE POLICY TO THE PROVISION OF HEALTH CARE TO BLACK FAMILIES**

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ED177259

INTRODUCTION

The black family in the United States of America has carried an inordinately heavy burden in terms of socioeconomic problems, health problems, and general abuse in a highly structured and pervasively racist society. The origin of today's problems has its antecedents in a slave society and slave economy, in which money took priority over human dignity. Yet in spite of the indignities, through residual ethos black American families have survived. Various structural forms of the family, such as the one-parent family, the nuclear family, and the extended family have contributed to American society. It is only appropriate that the strength of black families be emphasized and national priority be given to the central factors which affect this strength.

This paper will address in particular, some health and social issues affecting the black family, socioeconomic indices which affect the black family, and the development of policy and programs which are appropriate for black families.

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HEALTH AND SOCIAL ISSUES,
AND THE BLACK AMERICAN FAMILY

The late Whitney Young, Executive Director of the Urban League in the early 1960's, pointed out that poor health has become the lot of black Americans, in addition to the numerous other disadvantages which have been imposed upon them. He indicated that if blacks were to catch up, they would need much more health care than whites, yet they get so much less.[1] A review of the current century's vital health statistics demonstrates the truth of Whitney Young's remarks right up to the present day.

The indices which will be provided in this paper to illustrate the current state of health in black America will include infant mortality, life expectancy, maternal mortality, physician and dental visits, and some selected death rates from specific causes.

Infant Mortality. The infant mortality rate in the United States in 1974 was 16.7 per 1000 live births. It was 14.8 for whites, and 26.8 for blacks and others, a difference of 12.0 or a deficit differential ratio of 81%. In 1950 the infant mortality rate was 29.2: 26.8 for whites and 43.9 for non-whites. In the 21-year period from 1950 to 1971, there was a decrease of 44.4% for whites and 39.0 for blacks.[2]

Pratt et al., in her study on infant and perinatal mortality in the United States, observed that the mean infant mortality rates for the period of 1961-1965 were as follows: a total rate of 25.1; for whites, 22.0; and for non-whites, 41.6. For the period of 1966-1970 the total rate was 21.7; 19.1 for whites and 34.6 for non-whites. And, for the

Table 1

FIVE YEAR PERIODIC INFANT MORTALITY RATE

Years	Total Rate	White	Non-white	Differential Ratios
1961-1965	25.1	22.0	41.6	1.86
1966-1970	21.7	19.1	34.6	1.81
1969-1973	19.3	17.1	29.3	1.71

*Differentials of non-white to white rates for infant mortality. The differential raio is calculated by dividing the specific rate for non-whites by the rate for whites.

Source: Pratt, M. W. et al., Infant and Perinatal Mortality Rates by Age and Race. Washington, D.C.: Maternal and Child Health Studies Project, 1976. Taken from Text Table 1, p. vii.

period of 1969-1973 the total rate was 19.3; 17.1 for whites, and 29.3 for non-whites.[3] Table 1 provides these data showing the differential ratios between the black and white rates for each time period.

The deficit differential ratios are 86% for the period 1961-1965; 81% for the period 1966-1970; and 71% for the period of 1969-1973. However, if these aggregate figures do not give an adequate picture of the proportional difference over an expanded period, for example the proportional difference (or deficit ratio) in infant mortality between blacks and whites increased from 66% to 80% from 1950 to 1971.[4] If the aggregate figure for the period 1969-1973 is compared with the 1950 figure, the deficit ratio increased from 66% to 71%.

Maternal Mortality Rate. In 1940, the maternal mortality rate was 7.7 per 1000 live births for blacks and other races, and for whites it

was 3.2 with a differential ratio of 2.416 or 242%. In 1960, the rate for whites was 0.2 per 1000 live births and 1.0 for blacks and other races. In 1974, the rate for whites was 0.1 and for blacks, 0.4.[5] Although there has been a general decrease in the actual numbers for whites and non-whites, the differential ratio has actually been increasing steadily over the years to a high of 6.000 in 1970. Since 1970 it dropped to a low of 3.000 in 1973, but in 1974 it had jumped to 4.000, 4 times the rate for whites.

Table 2

MATERNAL MORTALITY RATES: 1940-1974
(per 1,000 births)

Year	Non-white	White	Ratio*
1940	7.7	3.2	2.416
1950	2.2	0.6	3.667
1960	1.0	0.2	5.000
1970	0.6	0.1	6.000
1971	0.5	0.1	5.000
1972	0.4	0.1	4.000
1973	0.3	0.1	3.000
1974	0.4	0.1	4.000

*Ratio indicates the number of times higher the black rate is compared to the white rate.

Source: Adapted from National Center for Health Statistics, U.S.P.H.S., "Vital Statistics of the United States, 1974," Vol. II, Mortality, Part A

Life Expectancy. The estimated average length of life at birth is the life expectancy for a cohort born during a given period. There has been a persistent difference of not less than 6 years in life expectancy between whites and blacks and other minorities since 1920. In 1973, the life expectancy was 68.4 and 61.9 respectively for white males and non-white males; and 76.6 and 70.1 respectively for white females and non-white females.[6] In 1920, the difference in life expectancy was 9.6 years, a change in the differential of 3.2 in over 50 years, or approximately 33% of the total dispartiy. If the present rate of life expectancy for whites remained constant, which of course it will not, it will be another 100 years before there is a parity in life expectancy between black and white Americans. (See Table 3)

Physician and Dental Visits. The clear evidence that blacks are getting much less medical care than whites is illustrated by physicians visits per year when whites and racial minorities are compared with control for economic status. In 1973, 16.8% of poor whites had no physicians visits compared to 18.5% of poor non-whites; and 12.7% of the nonpoor whites as compared to 13.5% of the nonpoor racial minorities.[7] These data were taken from the National Center for Health Statistics, and from unpublished data from the Health Interview Survey. (These surveys, as well as the dicennial census, tend to miss a large segment of the low income black population.)

When dental care is analyzed with respect to race, the disparity remains despite controls for economic status. In 1975, persons from the white population averaged 1.7 dental visits per year while blacks

Table 3

ESTIMATED AVERAGE LIFESPAN AT BIRTH*

Year	TOTAL			WHITE			NON-WHITE			DIFFERENCE BETWEEN WHITE AND NON-WHITE		
	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
1920	54.1	53.6	54.6	54.9	54.4	55.6	45.3	45.5	45.2	-9.6	-8.6	-10.4
1930	59.7	58.1	61.6	61.4	59.7	63.5	48.1	47.3	49.2	-12.3	-12.4	-14.3
1940	62.9	60.8	65.2	64.2	62.1	66.6	53.1	51.5	54.9	-11.1	-10.6	-11.7
1950	68.2	65.6	71.1	69.1	66.5	72.2	60.8	59.1	62.9	-8.3	-7.4	-9.3
1960	69.7	66.6	73.1	70.6	67.4	74.1	63.6	61.1	66.3	-7.0	-6.3	-7.8
1970	70.8	67.1	74.6	71.7	68.1	75.4	64.6	60.5	68.9	-7.1	-7.6	-6.5
1971	71.1	67.4	74.9	71.9	68.3	75.7	65.2	61.3	69.4	-6.7	-7.0	-6.3
1973	72.3	68.0	76.0	73.0	68.4	76.1	66.0	61.9	70.1	-6.3	-6.5	-6.0

*1970, 1971, and 1973, preliminary data

Source: Adapted and calculated from Statistical Abstracts of the United States, United States Department of Commerce, 1971, p. 53, and 1973, p. 57. All figures indicate a deficit in life expectancy among non-whites as compared to whites.

in the same income group averaged only 0.8 visits. In the income bracket of $5,000-9,999, whites averaged 1.4 visits, but blacks from the same group averaged only 1.1 visits, and for persons whose incomes exceeded $10,000, whites averaged 2.0 visits per year, while blacks averaged only 1.2 visits.[8] (See Table 4)

Table 4

DENTAL VISITS BY RACE AND INCOME, 1974

Characteristic	Visits Per Person Per Year
Race	
White	1.7
Racial Minority	1.0
Black Only	1.0
Income	
Under $3,000	1.1
$3,000-4,999	1.1
5,000-6,999	1.1
7,000-9,999	1.5
10,000-14,999	1.6
15,000-24,999	2.0
25,000+	2.6

Source: U.S.P.H.S., National Center for Health Statistics, unpublished data, Health Interview Survey

While the indices of medical and dental care reveal significant racial disparities between blacks and whites from the identical socio-economic groups, they also reveal a disparity between poor and non-poor persons when race is controlled. When we consider the fact that in 1975 the median income for blacks was less than $8,000 compared to the white median in excess of $13,500, it becomes evident that the racial disparity in medical care is greatly exacerbated by the fundamental economic inequity which separates racial minorities from the mainstream of affluent society.

Selected Death Rates from Specific Causes. In 1969 the death rate from all causes in the United States was 730.9 per 100,000 estimated midyear population. The rate for whites was 694.4 per 100,000 population and 1,046.2 for all others. The difference was 351.8 per 100,000 population. In other words, 351.8 more non-white persons per 100,000 non-white population were dying than whites. In reviewing some of the specific causes, the rate for major cardiovascular diseases was 341.1 for whites and 457.9 for non-whites, a difference of 116.5 per 100,000 population; for malignant neoplasms, 126.8 for whites and 158.6 for non-whites, a difference of 31.8 per 100,000 population; for accidents, 52.6 for whites and 75.5 for non-whites, a difference of 22.9 per 100,000 population; for influenza and pneumonia, 22.9 for whites and 41.9 for non-whites, a difference of 19.6 per 100,000 population; for diabetes mellitus, 13.2 for whites, 27.7 for non-whites, a difference of 14.5 per 100,000 population; for cirrhosis of the liver, 12.9 for whites and 24.0 for non-whites, a difference of 11.1 per 100,000 population; for

Table 5

AGE-ADJUSTED DEATH RATES FOR SPECIFIED CAUSES, BY COLOR, PER 100,000 POPULATION
UNITED STATES, 1969

CAUSE OF DEATH	Total	White	Non-white	Difference between White and Non-White	Differential Ratio	% Higher for Non-whites
All causes	730.9	694.5	1046.2	351.7	0.506	51%
Major cardiovascular disease	352.0	341.4	457.9	116.5*	0.340	34%
Diseases of the heart	262.3	257.1	312.8*	55.7*	0.210	21%
Hypertension	3.0	2.4	9.5	7.1	2.960	296%
Cerebrovascular disease	68.5	63.8	117.1	53.3	0.860	86%
Arteriosclerosis	9.2	9.2	9.1	0.1**	0.011	-1%
Malignant neoplasms	129.7	126.8	158.6	31.8*	0.250	25%
Accidents	55.3	52.6	75.5	22.9*	0.430	43%
Motor vehicle	28.5	27.9	33.7	5.8*	0.210	21%
All other	26.8	24.8	41.8	17.0*	0.690	69%
Influenza and pneumonia	24.6	22.3	41.9	19.6*	0.880	88%
Diabetes mellitus	14.5	13.2	27.7	14.5*	1.100	110%
Cirrhosis of the liver	14.2	12.9	24.0	11.1*	0.860	86%
Bronchitis, emphysema, asthma	12.0	12.0	10.0	2.0**	0.200	-20%
Tuberculosis, all forms	2.3	1.7	8.0	6.3*	3.710	371%

*Indicates differences in higher death rates per 100,000 blacks and other non-whites
** Indicates differences in higher death rates per 100,000 for whites

Source: National Center for Health Statistics, Monthly Vital Statistics Report, "Advance Report -- Final Morbidity Statistics, 1969," July 25, 1972

tuberculosis, all forms, 1.7 for whites and 8.0 for non-whites. These data indicate differential ratios from .330 or 33% for major cardiovascular diseases to 4.70 or 470% for all forms of tuberculosis.[9] (See Table 5)

SOCIOECONOMIC INDICES AND THE BLACK AMERICAN FAMILY

The black family has consistently been plagued by unemployment, great over-representation of employment in low-paying jobs, and a continuous decrease in absolute income as compared to the white population.

Unemployment, Employment, and Occupation Characteristics. In the first quarter of 1975 there wer over 7.6 million persons unemployed in the United States. This represented 7.5% of the total employable population. Of the total number employed, 1.425,000 were blacks and persons from other racial minorities. This is a ratio of 13.7% of the total employable population. For the white population the ratio was 7.6.[10] There was a deficit ratio of 76.3% for the non-white population of the U.S. as compared to whites. (See Table 6)

Correlated closely with the high rate of unemployment is the distribution of those actually employed by type of occupation. In 1974, of the 85,936,000 persons employed in the United States, 9% were black. Six percent of the total in white collar occupations were black, 12% of the blue collar jobs were black, 19% of the service workers were black, and 21% of those in personal services, including private household workers , were black. These figures are not consistent with the black

Table 6

UNEMPLOYMENT BY RACE IN 1975

	Employable Population	Unemployed	% Unemployed
White	81,250,000	6,175,000	7.6
Black	10,634,320	1,425,000	13.4
Total	91,884,320	7,600,000	8.3

Source: U.S. Department of Labor, Bureau of Labor Statistics

population base of 11%. On the other hand there is a slight over-representation in numbers in health services and education.[11] In health services, however, the major proportion are in the non-professional aide category. (See Table 7)

Income. Because of the discrimination, racism, and selective employment practices of institutions and industrial complexes as well as local, state, and federal governmental agencies, the incomes of black families have lagged behind white families. This differential in income is clear evidence of the major social inequalities in the United States. For example, in 1969, the median income for white families was $9,794, while for black families the income level was $6,191 (a deficit difference of $3,603). That is, a black family on the average earned 63% of the income of the average white family, a deficit differential of 60%.[12] In 1974, the median income for white families was $13,356, while for black families the income was $7,808, which amounted to a deficit of $5,548, or 58% of the average income of white

Table 7

OCCUPATION OF THE EMPLOYED POPULATION BY RACE, 1974
(numbers in thousands, annual averages)

	Total	Black	White	% of Black Total	% of White Total
Total employed	85,936	8,112	76,620	9	91
White-collar workers	41,738	2,302	38,761	6	94
Professional, technical	12,338	710	11,368	6	94
Managers, administrators	8,941	277	8,562	3	97
Sales workers	5,417	158	5,203	3	97
Clerical workers	15,043	1,202	13,629	8	92
Blue-collar workers	29,776	3,411	26,029	12	88
Service workers	11,373	2,130	9,037	19	81
Farm workers	3,048	225	2,793	7	93
Farmers, managers	1,643	51	1,579	3	97
Laborers, supervisors	1,405	174	1,214	12	88

Source: U.S. Department of Labor, Bureau of Labor Statistics, extracted from p. 75, "The Social and Economic Status of the Black Population in the United States, 1974."

families with a deficit differential ratio of .71 or 71%.[13] During this 5-year period there was a net decrease of over 11 percentage points for black families or an absolute decrease in buying power for black families (as compared to whites) of 18.3%. This is significant because black families were already behind. (See Table 8)

Narcotic and Drug Use. Drug use in the black community is a major problem. The crippling of black families cannot be accurately determined however, a few cases can be cited and by extrapolation, the progressive worsening of the problem can be predicted. Ward makes the following statement:

Table 8

MEDIAN INCOME OF FAMILIES, BY RACE, SELECTED YEARS**

Year	Median Income		% of Blacks to White	Differential Deficit Ratio*
	Black Families	White Families		
1967	$4,875	$8,234	.59	69%
1969	$6,191	$9,794	.63	60%
1970	$6,279	$10,236	.61	63%
1971	$6,440	$10,672	.60	66%
1972	$6,864	$11,549	.59	68%
1973	$7,269	$12,595	.58	73%
1974	$7,808	$13,356	.58	71%

*The differential deficit ratio indicates the percentage more buying buying power white families have than black families.

**Adapted from U.S. Bureau of the Census, Current Population Reports, Series P-23, No. 54, "The Social and Economic Status of the Black Population of the United States, 1974."

> In the April 1972 City Almanac, Graham Finney, then commissioner of the Addiction Services Agency (ASA), described the extent of heroin addiction in New York City. Estimates of the population suggested 150,000 as a consensus figure. Among those in ASA programs, 41.8% were black and 20.8% Puerto Rican. Finney adds that the proportion of addicts who are minority group members is higher among younger age groups. Most reports indicate that about three-quarters of the treatment population is male. In August of 1971, about half of those in treatment were under 24 years of age. The addiction rate approaches 6% in Central Harlem, followed by South Bronx and Bedford Stuyvesant. These areas are generally regarded as the most disadvantaged in the city. . .to quote the August 1971 Addiction Services census, the model enrollee "tends to be black, male, between the ages of 20 and 24."[14]

In a study by Johnson, it was observed that during high school marijuana use among blacks was approximately 30% and for whites around 20%. After high school marijuana use among blacks rose to 40% and for whites it rose to 34%. In the case of heroin use, it was 8% during high school for blacks, and 6.9% after high school. For whites, the use of heroin was 0.7% during high school, then rose to 2% after, but only 0.7 used heroin on more than an experimental basis.[15]

Although the above study may not be truly representative, these data indicate a trend in which inferences must be made, particularly since the sample was made up of 1577 whites and 198 blacks, which is a black representation of 11.2% and fairly consistent with the overall population rates in the United States. One could even project the immensity of the problem as follows: during 1975-76, there were 20,356,000 students enrolled in secondary high schools in the United

States. There were 3,135,000 graduating high school seniors. If we use conservative figures and say 12.5% were black graduating seniors, this would mean 375,000 black high school graduates. If 7% of these students used heroin on more than an experimental basis there could be 26,300 black users added to the population each year from high school graduates only. If the number of graduates remained constant and 75% of these experimental users became addicts, again a conservative figure, there would be 130,000 more black addicts with high school diplomas on the street in five years time. The figure for whites who used heroin on more than an experimental basis, and at the same 75% rate of addiction, would indicate that there could be 72,200 more white addicts on the street in five years time. This could mean more than 200,000 new addicts, all of whom would be high school graduates in five years time, of which 60% would be black addicts.[16]

THE DEVELOPMENT OF POLICY AND PROGRAMS SUITABLE FOR BLACK FAMILIES: A CHALLENGE TO THE BLACK COMMUNITY AND CIVIL RIGHTS ORGANIZATIONS

The major theme of this conference, "The Black Family: A Source of National Strength," is timely and appropriate as efforts are being made to develop policy in health care. Just as black Americans led this country out of overt apartheid in the civil rights movement and gave impetus to the end of the war in Vietnam, and provided guidelines for the modern Women's Movement, black Americans and black families can lead the way to a modernistic, updated, humanistic, health delivery system for all families in the United States. In other words, what I am proposing will improve and promote the health of all families and not just that of black families.

Policy development must start at the source of the need. We have waited too long for policy in health care to develop in Washington. The political constraints placed on lawmakers, and pressure by the American Medical Association, drug companies, and other vested interests have delayed action which will affect black families.

Also, most health programs and legislative policy for health care in the United States have been designed and developed to meet the needs and desires of the wealthy white population and not the needs of middle income, middle low income, and low income Americans, regardless of race, creed, or ethnic background. Since health program development has not been designed for these groups these programs cannot meet the needs of black families. This is evident from the data presented earlier.

When compounded problems in the black community are analyzed it is seen that health services per se are just one aspect of the many needs, and that social, economic, and political factors have all had a direct affect on the health of the black people. A concerted and coordinated effort is necessary to solve problems in the black community, and policy development must be based on this consideration. First and foremost, if we accept the definition of health given by the World Health Organization,[17] "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity," we can approach the solution in a "holistic" manner. One of the truisms in the black community is that the present practice of medical care based on fee-for-service is inconsistent with the economic and social conditions of the black family. Another truism is that a medical program devoid of community

development, community building, community control, and family participation in policy development and implementation is ineffective. Finally, to approach both of these problems, we as black Americans must not only accept the principle that "health is a right and must become a social responsibility," but we must work for needed legislation to achieve this goal.[18] In this connection Cornely says:

> The abolition of charity must be implemented with the passage of legislation establishing a national health insurance scheme dedicated to the principle that every individual in the United States has a right to medical care.[19]

Such legislation will create a more humanistic approach to health care for blacks and eliminate and change present health care which is now offered on an unequal basis. Such legislation will permit turning attention to comprehensive action on other problems in the black community which are sorely needed as illustrated by English, who points out that there is need for a comprehensive approach to health problems in which all factors associated with life, life style, and the socio-economic factors must be considered. He says:

> We know that if we guaranteed a marginal income for a full year to every poor American, at the end of that year almost none would have escaped from poverty.
>
> This is because poverty is a lack of education, of training, for a marketable skill; it is not having access to a lawyer, physician or a pharmacist when these are needed. Poverty is living in the darkness of the slum. It's being a child of the ghetto, a Mexican-American, or a Negro in Hough or Harlem.
>
> We also have begun to understand that the welfare check is not a one-way ticket out of poverty -- that it's merely a claim check on a subsistence life. A welfare check may buy food or clothing or pay the rent but it doesn't buy skills, motivation or -- that scarcest of all commodities among the poor -- hope. We also have come to understand that there is not need of the poor which is greater than the need for good health.[20]

This need is further illustrated by Watkins in her study among a group of low-income black mothers. She says:

> The socio-economic characteristics of these mothers and the severity of their social problems emphasize that the provision of comprehensive maternity care is incomplete unless there is concurrent social planning for adequate income, decent housing, and increased opportunities in education and employment for these families.[21]

These problems are compounded by an unemployment rate of over 40% among black teenagers, correlated with hopelessness, hostility, pessimism, despondency, and feelings of loss or lack of fate control. The issue is clear because an individual in a hopeless state of mind, and who day after day is rejected for employment will seek some method of escape. This is the lot of black teenagers. It would be useful to know how many black high school graduates who use heroin on more than an experimental basis are from a poverty situation, are unemployed, who live in poor housing, who have unsuccessfuly sought employment week after week, and who openly feel the strain of discrimination and segregation.

These needs indicate that there is real challenge to black community as a whole and specifically to the National Urban League and other civil rights organizations such as the NAACP, CORE, SCLEC as well as black social fraternities, sorities, black social clubs, and various black civic groups.

Specifically, it is imperative that policy be developed which will address the problem of poor health among the underprivileged members of this American society. We have demonstrated unequivocally that blacks and poor people suffer from poorer health than other people. But if we are to attack this issue squarely, we must attack the fundamental root

of the problem, which is a system of medical care delivery founded on the principle of private enterprise within a capitalistic, stratified society in which the treatment of illness and sick people is directed by the profit motive. Such a system -- our present system of medical care -- allows racism and socioeconomic disparity to flourish such that the medical care profession is not a health care profession and instead operates in favor of the rich and profits at the expense of the poor, the ignorant, and the economically under-privileged.

We must work forward toward change to bring about a solution to these problems and our goals should be aimed at fundamental reorganization of the present system of health care delivery, at re-educating both consumers and providers of health care with new concepts of health, and at focusing special attention on those groups that have been particularly exploited.

Specifically:

(1) The present system of health care delivery should undergo organizational changes to eliminate discrimination in favor of the wealthy and the health care profession itself. Therefore, we must move toward a program of national health insurance to replace the present system of fee-for-service. We should work toward the establishment of a nonprofit organization of consumers who will employ the medical and health staff and who will lay down their own methods for evaluating the health delivery process.

(2) The consuming public and health care professionals alike should be re-educated toward new concepts of health; that is, that health is a right, that health is a moral

and social responsiblity, and that health is a total mental and social situation and not just the absence of disease or infirmity. We should work to develop programs of community health education and re-orient the teaching of the health concept in medical schools, schools of public health, schools of nursing, and schools of social work.

(3) We must help those groups that have been particularly exploited -- blacks, Spanish Americans, native American Indians -- to catch up. Therefore, special programs should be developed to deal with the special problems of these under-represented groups. For instance, it is recommended that the federal government establish a special commission to deal with the health problems of these groups and that this commission have a mandate of extended life and the same type of power that the Civil Rights Commission has.

(4) Health care must be rebased within the community which will have the power to establish new standards of health care and the responsibility of educating the consuming public to accept and expect these new standards. Therefore, we must establish community organizations which will set up standards of quality control, medical staff evaluation, and which will educate consumers in methods of preventive health care so that health becomes the central issue, rather than sickness, in the program of health care delivery.

(5) Health is not an isolated problem. Therefore, health workers and social workers must be educated and re-educated to work together to develop a new approach to health care which integrates the social and related factors into the health care delivery process.

(6) And finally, because health care is a social problem, it is also a political issue and should be dealt with as such; we must work to remove health care from the cloak of secrecy of the doctor-patient relationship. Consumers, and particularly minority groups, must be taught to work through the political process and put pressure on congressional state legislatures, on Congress, on state and local governments so that health care programs can be developed to suit the needs of the individuals and specific communities which they must serve.

SUMMARY

The black family in the United States has carried an inordinately heavy burden in terms of socioeconomic problems, a problem which has its antecedents in a slave economy. In almost every health indice, black Americans are disproportionately represented in terms of poorer health; for example, infant mortality, life expectancy at birth, physician and dental visits, and in adjusted death rates for specific causes.

In addition to the health indicators, the black American family is characteristically subject to higher unemployment rates; lower incomes when employed; and high employment in the blue collar sector, service and domestic work, and in the unskilled labor categories.

These problems can only be addressed by a system in which health is considered of value to the individual and health care is based on a preventive, promotive model. The profit motive for treating illness must be de-emphasized and phased out and replaced with rewards for keeping people well. A health care system which will be community-based, which will have community sanction, and which will be controlled and evaluated by those whom it serves, with special emphasis on the socioeconomic problems of black and other minorities, should be developed.

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